

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12513

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whiteford		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle J. Last AIKENS		4. DATE OF DEATH Month Dec. Day 30 Year 19 56	
5. SEX Male	6. COLOR OR RACE Colored	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH July 28 1929
9. AGE (In years last birthday) 27		10. IF UNDER 1 YEAR Months 2 Days 28	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer Abner Proving Ground Harford County		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph E. Aikens		14. MOTHER'S MAIDEN NAME Gertrude Aikens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 242-32-4766	
17. INFORMANT Joseph Aikens		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exposure following automobile accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto overturned, collapsed after walking 5 miles from scene	
20c. TIME OF INJURY Month, Day, Year 12/30/ 19 56	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) (County) (State) Rt. 136 Harford Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. S. Fisher M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/31/56	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial Jan 3 1957 Green Spring Harford Co Md		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Green Spring Harford Co Md		22d. LOCATION (City, town, or county) (State) Harford Md	
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Bailey		24. REGISTRAR'S SIGNATURE C. H. Fisher	

BUREAU V.

JAN 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12532

CERTIFICATE OF DEATH

12514
 Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>				c. LENGTH OF STAY IN 1b <u>25 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR MD</u>			
				d. STREET ADDRESS <u>105 E Broadway</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lavinia Boorman Bradford</u>				4. DATE OF DEATH Month Day Year <u>Dec 14 1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 23-1872</u>	
				9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Black Horse Hartford MD</u>			
11. BIRTHPLACE (State or foreign country) <u>US</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>BENJAMIN F BOORMAN</u>				14. MOTHER'S MAIDEN NAME <u>FRANCES HOLLAND</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>			
				17. INFORMANT <u>Miss Lavinia Bradford</u> Address <u>105 E Broadway BEL AIR MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia, terminating</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Cerebral Thrombosis--Hemiplegia</u> DUE TO (c) <u>Chr. Cardio-vascular disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb. 2</u> , 1956, to <u>Dec. 14</u> , 1956, that I last saw the deceased alive on <u>Dec. 13</u> , 1956, and that death occurred at <u>7:45</u> a.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Forest Hill Md.</u> DATE SIGNED <u>12-14-56</u> ACTUAL SIGNATURE <u>Willard P. Hudson</u> PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Dec 17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Spring Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Forest Hill Hartford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph H. Hudson</u> ADDRESS <u>Med.</u>				24a. REC'D BY REGISTRAR <u>DATE 12-14-56</u>		24b. REGISTRAR'S SIGNATURE <u>Pravilla Lowmood</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V.

DEC 17 1956

RECEIVED

12551

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STREET				c. LENGTH OF STAY IN 1b 4 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS STREET			
3. NAME OF DECEASED (Type or print) First ALLEN Middle LOGAN Last BRIDGES				4. DATE OF DEATH Month DEC. Day 10 Year 1956			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 14, 1903	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RECORDER				10b. KIND OF BUSINESS OR INDUSTRY STEEL		11. BIRTHPLACE (State or foreign country) ALABAMA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME LOGAN BRIDGES				14. MOTHER'S MAIDEN NAME MARY S. GOUVERNORIC			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES				16. SOCIAL SECURITY NO. 107-07-7635		17. INFORMANT Address MRS. GLADYS BRIDGES, STREET, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 200.1 DUE TO mention Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension DUE TO paroxysm (c) 4 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June , 19 56 to December 10 , 19 56 , that I last saw the deceased alive on December 9 , 19 56 , and that death occurred at 1:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) C H R D I F R DATE SIGNED 12-12-56							
ACTUAL SIGNATURE Benjamin Dorogi, M.D.				PHYSICIAN'S NAME (Type) BENJAMIN DOROGI, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-13-56		22c. NAME OF CEMETERY OR CREMATORY BELAIR GARDENS		22d. LOCATION (City, town, or county) (State) BELAIR, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Haskins, Delta, Pa.				24a. REC'D BY REGISTRAR DATE 12-12-56		24b. REGISTRAR'S SIGNATURE Priscilla Lowwood	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1953

1. PLACE OF DEATH		2. COUNTY	
3. MARITAL STATUS		4. OCCUPATION	
5. CAUSE OF DEATH		6. MANNER OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH	
9. SEX		10. AGE	
11. RACE		12. BIRTH DATE	
13. BIRTH PLACE		14. BIRTH DATE	
15. BIRTH TIME		16. BIRTH PLACE	
17. BIRTH DATE		18. BIRTH TIME	
19. BIRTH PLACE		20. BIRTH DATE	
21. BIRTH TIME		22. BIRTH PLACE	
23. BIRTH DATE		24. BIRTH TIME	
25. BIRTH PLACE		26. BIRTH DATE	
27. BIRTH TIME		28. BIRTH PLACE	
29. BIRTH DATE		30. BIRTH TIME	
31. BIRTH PLACE		32. BIRTH DATE	
33. BIRTH TIME		34. BIRTH PLACE	
35. BIRTH DATE		36. BIRTH TIME	
37. BIRTH PLACE		38. BIRTH DATE	
39. BIRTH TIME		40. BIRTH PLACE	
41. BIRTH DATE		42. BIRTH TIME	
43. BIRTH PLACE		44. BIRTH DATE	
45. BIRTH TIME		46. BIRTH PLACE	
47. BIRTH DATE		48. BIRTH TIME	
49. BIRTH PLACE		50. BIRTH DATE	
51. BIRTH TIME		52. BIRTH PLACE	
53. BIRTH DATE		54. BIRTH TIME	
55. BIRTH PLACE		56. BIRTH DATE	
57. BIRTH TIME		58. BIRTH PLACE	
59. BIRTH DATE		60. BIRTH TIME	
61. BIRTH PLACE		62. BIRTH DATE	
63. BIRTH TIME		64. BIRTH PLACE	
65. BIRTH DATE		66. BIRTH TIME	
67. BIRTH PLACE		68. BIRTH DATE	
69. BIRTH TIME		70. BIRTH PLACE	
71. BIRTH DATE		72. BIRTH TIME	
73. BIRTH PLACE		74. BIRTH DATE	
75. BIRTH TIME		76. BIRTH PLACE	
77. BIRTH DATE		78. BIRTH TIME	
79. BIRTH PLACE		80. BIRTH DATE	
81. BIRTH TIME		82. BIRTH PLACE	
83. BIRTH DATE		84. BIRTH TIME	
85. BIRTH PLACE		86. BIRTH DATE	
87. BIRTH TIME		88. BIRTH PLACE	
89. BIRTH DATE		90. BIRTH TIME	
91. BIRTH PLACE		92. BIRTH DATE	
93. BIRTH TIME		94. BIRTH PLACE	
95. BIRTH DATE		96. BIRTH TIME	
97. BIRTH PLACE		98. BIRTH DATE	
99. BIRTH TIME		100. BIRTH PLACE	

BUREAU V. A.

DEC 14 1956

RECEIVED

12533 CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. LENGTH OF STAY IN 1b <u>1 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>464 Alliance St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>R.</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-19-56</u>	
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>16</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Sumpter, S.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Richard A. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Juanita Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Juanita Brown</u>		Address <u>464 Alliance St. Harre de Grace, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gastroenteritis</u> DUE TO (c) <u>Bronchitis with Aspiration</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>12/19</u> , 19 <u>56</u> , to <u>12/29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/29</u> , 19 <u>56</u> , and that death occurred at <u>8:15 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George T. Stansbury</u>				ADDRESS (Street, city or town, state) <u>569 Revolution St., Harre de Grace, Md.</u>			
DATE SIGNED <u>12/29/56</u>							
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>				<u>HARRE DE GRACE, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-30-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>N. Aberdeen, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Otelia J. Bullock</u>				ADDRESS <u>556 Lewis St.</u>		24a. REC'D BY REGISTRAR <u>DATE 1-30-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 2 1957
BUREAU U. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 1041

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

12517

Reg. Dist. No. 186

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND CITY OR TOWN <u>Harre-de-Grace</u> LENGTH OF STAY <u>16 WEEKS</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>Harford</u> CITY OR TOWN <u>Harre-de-Grace</u> STREET ADDRESS <u>Box 72, R.D.#1</u>			
3. NAME OF DECEASED (Type or Print) <u>Harry</u> (First) <u>Poland</u> (Middle) <u>Burkentine</u> (Last)			4. DATE OF DEATH <u>DEC. 19, 1956</u> (Month) (Day) (Year)				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>MAY 30, 1877</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>			
13. FATHER'S NAME <u>Thomas Burkentine</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Della Burkentine (Wife)</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis Generalized</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>C</u>				18. MEDICAL CERTIFICATION <u>HARRE-DE-GRACE, MD.</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/27/56</u> , 19 <u>56</u> , to <u>12/19/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/19/56</u> , 19 <u>56</u> , and that death occurred at <u>Harre-de-Grace, Md.</u> M, from the causes and on the date stated above. SIGNATURE <u>Wm L. Wachman</u> M.D. ADDRESS <u>Harre-de-Grace, Md.</u> DATE SIGNED <u>12/20/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-23-1956</u>		NAME OF CEMETERY, OR CREMATORY <u>Angel Hill</u> LOCATION (City, town, or county) <u>Harre-de-Grace, Harford, Md.</u> (State)			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>A. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Madison Mitchell</u> ADDRESS <u>Harre-de-Grace, Md.</u>			
DATE <u>12-23-56</u>							

A34

CERTIFICATE OF DEATH

Case No. 12

1. FOLLOWS DEATH

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PERMANENT RESIDENCE

DATE OF INTERVIEW

INTERVIEWER

DATE OF ENTRY

ENTRY

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PERMANENT RESIDENCE

DATE OF INTERVIEW

INTERVIEWER

DATE OF ENTRY

ENTRY

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PERMANENT RESIDENCE

DATE OF INTERVIEW

INTERVIEWER

DATE OF ENTRY

ENTRY

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PERMANENT RESIDENCE

DATE OF INTERVIEW

INTERVIEWER

DATE OF ENTRY

ENTRY

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PERMANENT RESIDENCE

DATE OF INTERVIEW

INTERVIEWER

DATE OF ENTRY

ENTRY

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PERMANENT RESIDENCE

BUREAU V. S.

DEC 27 1956

RECEIVED

DISCONTINUATION

RECEIVED
DEC 27 1956
BUREAU V. S.

TO TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12518
12552										CERTIFICATE OF DEATH
Reg. Dist. No. 181										
1. PLACE OF DEATH a. COUNTY Harford MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen			c. LENGTH OF STAY IN 1b -		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital					d. STREET ADDRESS 9 Glyndon			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MIDDLE LAST ELIZABETH ANN BURKHARDT					4. DATE OF DEATH December 19 1956					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 19, 1956		9. AGE (In years last birthday) yrs. 1 45		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Charles Burkhardt					14. MOTHER'S MAIDEN NAME Georgette Juliette Germain					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Father Address same as in 2 above					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis 560.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diaphragmatic Hernia w/mediastinal shift;bilateral compression of lung. (c) Thorax contained 2/3 lobe liver & maj.portion of small gut PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity INTERVAL BETWEEN ONSET AND DEATH 1 hr 45 min										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from December 19, 1956, to December 19, 1956, that I last saw the deceased alive on December 19, 1956, and that death occurred at 05:15a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Joseph R. Gabriels M.D. US Army Hospital Dec 19, 1956 PHYSICIAN'S NAME (Type) JOSEPH R GABRIELS Captain, MC Aberdeen Proving Ground, Md.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 12/21/56		22c. NAME OF CEMETERY OR CREMATORY Rest Cemetery			22d. LOCATION (City, town, or county) (State) Camp Chapman Gith Md		
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tamm					ADDRESS Aberdeen		24a. REC'D BY REGISTRAR DATE Dec 21-56		24b. REGISTRAR'S SIGNATURE Nellie R Perry	

2050306XV2

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Manner of Death		Occupation		Residence	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Burial		Place of Burial		Cause of Burial	
Manner of Burial		Occupation		Residence	
Signature of Minister		Signature of Registrar		Signature of Coroner	
Date of Interment		Place of Interment		Cause of Interment	
Manner of Interment		Occupation		Residence	
Signature of Minister		Signature of Registrar		Signature of Coroner	
Date of Cremation		Place of Cremation		Cause of Cremation	
Manner of Cremation		Occupation		Residence	
Signature of Minister		Signature of Registrar		Signature of Coroner	
Date of Disposition		Place of Disposition		Cause of Disposition	
Manner of Disposition		Occupation		Residence	
Signature of Minister		Signature of Registrar		Signature of Coroner	

RECEIVED
DEC 20 1916
BUREAU V. S.

12535

CERTIFICATE OF DEATH

Reg. Dist. No. 180-

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>	
c. LENGTH OF STAY IN 1b <u>13 days</u>		d. STREET ADDRESS <u>Washington & Bourbon St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Henry</u> Last <u>Chook</u>		4. DATE OF DEATH Month <u>12</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/16/1886</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City of Hartford</u>	
11. BIRTHPLACE (State or foreign country) <u>Hartford Conn. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Henry Chook</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Price</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Edward Chook (brother)</u>		Address <u>606 W. Adams St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Hypertension and Myocarditis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 day</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 1951, to <u>Dec 23</u> , 1956, that I last saw the deceased alive on <u>December 23</u> , 1956, and that death occurred at <u>535</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank Wolbert MD</u> M.D.		ADDRESS (Street, city or town, state) <u>200 North Union Ave.</u> DATE SIGNED <u>12/26/56</u>	
PHYSICIAN'S NAME (Type) <u>FRANK WOLBERT MD</u>		<u>Hartford Conn Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12/26/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Hartford Conn Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick J. Con</u>		24a. REC'D BY REGISTRAR <u>12/26/56</u> 24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis MD</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12520

Reg. Dist. No. 135-

CERTIFICATE OF DEATH

12536

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>102 S. Union Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Michael</u> Last <u>Coale</u>		4. DATE OF DEATH Month <u>December</u> Day <u>10</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/12/66</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BANKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John B. Coale</u>		14. MOTHER'S MARDEN NAME <u>E. Miley B. Woolford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>17. INFORMANT</u> <u>Mrs. Maude D. Coale</u> Address <u>Harre de Grace, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio sclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>420.0</u> DUE TO (c) <u>420.0</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 10</u> , 19 <u>56</u> , to <u>Dec 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 10</u> , 19 <u>56</u> , and that death occurred at <u>5:17</u> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Harre de Grace, Md.</u> DATE SIGNED <u>12-10-56</u>	
ACTUAL SIGNATURE <u>E. J. Simon</u> M.D.		PHYSICIAN'S NAME (Type) <u>E. J. Simon</u> <u>HARRE DE GRACE, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-13-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>HARRE DE GRACE, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> ADDRESS <u>Harre de Grace, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 12-13-56</u> 24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MEDICAL HISTORY</p>		<p>10. DATE OF DEATH</p>	
<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF PHYSICIAN</p>	
<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF WITNESS</p>	

BUREAU V. 3

DEC 14 1956

RECEIVED

CERTIFICATE OF DEATH

12553

1. PLACE OF DEATH o. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Claude Middle T. Last Crouse, Jr.				4. DATE OF DEATH Month Dec. Day 20 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 9, 1914		9. AGE (In years last birthday) yrs. 42	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Food Market		11. BIRTHPLACE (State or foreign country) Balto., Md.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Claude T. Crouse				14. MOTHER'S MAIDEN NAME Lottie Meier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-03-2978		17. INFORMANT Address Mrs. M. Virginia Crouse, Joppa, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 4 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-20 , 19 56 , to 12-20 , 19 56 , that I last saw the deceased alive on 12-20 , 19 56 , and that death occurred at 6P M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Gerald C. Palmer M.D.				ADDRESS (Street, city or town, state) Bel Air Md. DATE SIGNED 12-22-56			
PHYSICIAN'S NAME (Type) Gerald C. Palmer				Bel Air Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 23, 1956		22c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran		22d. LOCATION (City, town, or county) (State) Joppa, Harford, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McCombs & Son				ADDRESS Abingdon Md.		24a. REC'D BY REGISTRAR Dec 25, 1956 24b. REGISTRAR'S SIGNATURE Norma G. Moore	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
DEC 27 1956

12554

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STREET				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STREET			
c. LENGTH OF STAY IN 1b 65 yrs.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NELLIE W. Middle DAY Last DAY				4. DATE OF DEATH Month DEC. Day 10 Year 1956			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 4, 1870	
				9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) HARFORD Co., MD.	
13. FATHER'S NAME WM. WILEY				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
14. MOTHER'S MAIDEN NAME REBECCA ROBINSON							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT MRS. C. RUSSELL GALBREATH, STREET, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE 432.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 5 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL VASCULAR ACCIDENT.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from MARCH 3 , 1951, to DEC. 10 , 1956, that I last saw the deceased alive on Dec 7 , 1956, and that death occurred at 2:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles A. Neff M.D.				ADDRESS (Street, city or town, state) Street, Md. DATE SIGNED 12-11-56			
PHYSICIAN'S NAME (Type) CHARLES A. NEFF M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-12-56		22c. NAME OF CEMETERY OR CREMATORY HIGHLAND		22d. LOCATION (City, town, or county) (State) STREET, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harrison, Delta, Pa.				42a. REC'D BY REGISTRAR DATE 12-12-56		24b. REGISTRAR'S SIGNATURE Phyllis L. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>WALTER C. GIBSON</i>		DATE OF DEATH <i>DEC 14 1956</i>	
AGE <i>70</i>		SEX <i>M</i>	
RACE <i>W</i>		RELIGION <i>Methodist</i>	
MARRIAGE <i>Married</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Retired</i>		RESIDENCE <i>1234 Main St, Baltimore, Md</i>	
PLACE OF DEATH <i>Home</i>			
CAUSE OF DEATH <i>Heart Disease</i>			
MANNER OF DEATH <i>Natural</i>			
SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>			
SIGNATURE OF REGISTRAR <i>John Doe</i>			
DATE OF REGISTRATION <i>DEC 14 1956</i>			

BUREAU V.

DEC 14 1956

RECEIVED

THE OFFICE OF THE REGISTRAR OF DEATHS
IS NOT RESPONSIBLE FOR THE
CORRECTNESS OF THE
INFORMATION FURNISHED
HEREON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12555

CERTIFICATE OF DEATH

12523 187
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hatford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Hatford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tarrettsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tarrettsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) First <u>Ida Elizabeth</u> Middle <u>Denbow</u> Last <u>Denbow</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 19 1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>29</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>Tarrettsville</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Andrew Cleveland Kimbark</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine Hise</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>G. Willard Denbow Tarrettsville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2nd</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Alzheimer's Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 1954, to <u>Dec. 8</u> , 1956, that I last saw the deceased alive on <u>Dec. 2</u> , 1956, and that death occurred at <u>5 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		ADDRESS (Street, city or town, state) <u>Parkton, Md.</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		DATE SIGNED <u>12/8/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 11-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel</u>	22d. LOCATION (City, town, or county) (State) <u>Madox 779 Hatford Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Kutz</u>		ADDRESS <u>Tarrettsville Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 13 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Priscilla Howard</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		DATE OF DEATH <i>12/15/56</i>	
AGE <i>45</i>		SEX <i>Male</i>	
RACE <i>White</i>		MARRIAGE <i>Married</i>	
OCCUPATION <i>Teacher</i>		CAUSE OF DEATH <i>Heart Disease</i>	
PLACE OF DEATH <i>Home</i>		DATE OF BURIAL <i>12/18/56</i>	
CITY <i>Westland</i>		COUNTY <i>Wayne</i>	
STATE <i>Michigan</i>		FEDERAL BUREAU OF INVESTIGATION <i>U.S. Department of Justice</i>	
SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	
DATE OF SIGNATURE <i>12/15/56</i>		DATE OF SIGNATURE <i>12/15/56</i>	
PLACE OF SIGNATURE <i>Home</i>		PLACE OF SIGNATURE <i>Home</i>	
CITY <i>Westland</i>		COUNTY <i>Wayne</i>	
STATE <i>Michigan</i>		FEDERAL BUREAU OF INVESTIGATION <i>U.S. Department of Justice</i>	
SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	
DATE OF SIGNATURE <i>12/15/56</i>		DATE OF SIGNATURE <i>12/15/56</i>	
PLACE OF SIGNATURE <i>Home</i>		PLACE OF SIGNATURE <i>Home</i>	
CITY <i>Westland</i>		COUNTY <i>Wayne</i>	
STATE <i>Michigan</i>		FEDERAL BUREAU OF INVESTIGATION <i>U.S. Department of Justice</i>	

RECEIVED
DEC 13 1956
BUREAU V. 3.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12556

CERTIFICATE OF DEATH

12524

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Bel Air)		c. LENGTH OF STAY IN 1b 38 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #1, Bel Air, Md.		d. STREET ADDRESS RFD #1, Bel Air, Md.	
3. NAME OF DECEASED (Type or print) First ORRIN Middle CLAYTON Last EDWARDS		4. DATE OF DEATH Month December Day 1 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 2, 1907
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant owner		10b. KIND OF BUSINESS OR INDUSTRY North Carolina	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George M. Edwards		14. MOTHER'S MAIDEN NAME Florence Evans	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-32-8280	
17. INFORMANT George M. Edwards, RFD #1, Bel Air, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic carcinoma DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 15 minutes 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic alcoholism and history of cirrhosis of liver.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 17, 1956 , to December 1, 1956 , that I last saw the deceased alive on November 17, 1956 , and that death occurred at 7:50 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul S. Stonesifer, Jr.		ADDRESS (Street, city or town, state) 115 Fulford Ave.	
PHYSICIAN'S NAME (Type) Paul S. Stonesifer, Jr.		DATE SIGNED 12/1/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Dec 13/1956 Mt. Zion Cem		22b. NAME OF CEMETERY OR CREMATORY Harford Co. Md.	
22c. LOCATION (City, town, or county) (State)		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Bailey		23b. REGISTRAR'S SIGNATURE Purcella Fawcett	
ADDRESS Harlington, Md.		DATE Dec 9, 1956	

CERTIFICATE OF DEATH

12358

1. PLACE OF DEATH HOSPITAL		2. NAME OF DECEASED JOHN J. SMITH	
3. SEX Male		4. AGE 65	
5. RACE White		6. DATE OF DEATH Dec 10, 1956	
7. TIME OF DEATH 10:00 AM		8. CAUSE OF DEATH Myocardial Infarction	
9. MANNER OF DEATH Natural		10. SIGNATURE OF PHYSICIAN J. H. BROWN	
11. SIGNATURE OF REGISTRAR M. J. WHITE		12. SIGNATURE OF WITNESSES A. J. GREEN, B. C. BLACK	
13. PLACE OF BIRTH Baltimore, Md.		14. DATE OF BIRTH Jan 15, 1891	
15. OCCUPATION Teacher		16. MARITAL STATUS Married	
17. EDUCATION High School		18. RELIGION Roman Catholic	
19. PREVIOUS ILLNESS Hypertension		20. MEDICATION None	
21. ALCOHOLIC BEVERAGE None		22. TOBACCO None	
23. DRUGS None		24. OTHER None	
25. SIGNATURE OF DECEASED None		26. SIGNATURE OF NEXT OF KIN None	
27. SIGNATURE OF SURVIVOR None		28. SIGNATURE OF BURIAL OFFICIAL None	
29. SIGNATURE OF MINISTER None		30. SIGNATURE OF CHURCH None	
31. SIGNATURE OF FUNERAL HOME None		32. SIGNATURE OF CEMETERY None	
33. SIGNATURE OF INTERVIEWER None		34. SIGNATURE OF SUPERVISOR None	
35. SIGNATURE OF CLERK None		36. SIGNATURE OF ASSISTANT None	
37. SIGNATURE OF RECEPTIONIST None		38. SIGNATURE OF TELEPHONE OPERATOR None	
39. SIGNATURE OF MAIL ROOM None		40. SIGNATURE OF RECORDS SECTION None	
41. SIGNATURE OF CHIEF OF BUREAU None		42. SIGNATURE OF DEPUTY CHIEF None	
43. SIGNATURE OF ASSISTANT CHIEF None		44. SIGNATURE OF CLERK None	
45. SIGNATURE OF RECEPTIONIST None		46. SIGNATURE OF TELEPHONE OPERATOR None	
47. SIGNATURE OF MAIL ROOM None		48. SIGNATURE OF RECORDS SECTION None	
49. SIGNATURE OF CHIEF OF BUREAU None		50. SIGNATURE OF DEPUTY CHIEF None	
51. SIGNATURE OF ASSISTANT CHIEF None		52. SIGNATURE OF CLERK None	
53. SIGNATURE OF RECEPTIONIST None		54. SIGNATURE OF TELEPHONE OPERATOR None	
55. SIGNATURE OF MAIL ROOM None		56. SIGNATURE OF RECORDS SECTION None	
57. SIGNATURE OF CHIEF OF BUREAU None		58. SIGNATURE OF DEPUTY CHIEF None	
59. SIGNATURE OF ASSISTANT CHIEF None		60. SIGNATURE OF CLERK None	
61. SIGNATURE OF RECEPTIONIST None		62. SIGNATURE OF TELEPHONE OPERATOR None	
63. SIGNATURE OF MAIL ROOM None		64. SIGNATURE OF RECORDS SECTION None	
65. SIGNATURE OF CHIEF OF BUREAU None		66. SIGNATURE OF DEPUTY CHIEF None	
67. SIGNATURE OF ASSISTANT CHIEF None		68. SIGNATURE OF CLERK None	
69. SIGNATURE OF RECEPTIONIST None		70. SIGNATURE OF TELEPHONE OPERATOR None	
71. SIGNATURE OF MAIL ROOM None		72. SIGNATURE OF RECORDS SECTION None	
73. SIGNATURE OF CHIEF OF BUREAU None		74. SIGNATURE OF DEPUTY CHIEF None	
75. SIGNATURE OF ASSISTANT CHIEF None		76. SIGNATURE OF CLERK None	
77. SIGNATURE OF RECEPTIONIST None		78. SIGNATURE OF TELEPHONE OPERATOR None	
79. SIGNATURE OF MAIL ROOM None		80. SIGNATURE OF RECORDS SECTION None	
81. SIGNATURE OF CHIEF OF BUREAU None		82. SIGNATURE OF DEPUTY CHIEF None	
83. SIGNATURE OF ASSISTANT CHIEF None		84. SIGNATURE OF CLERK None	
85. SIGNATURE OF RECEPTIONIST None		86. SIGNATURE OF TELEPHONE OPERATOR None	
87. SIGNATURE OF MAIL ROOM None		88. SIGNATURE OF RECORDS SECTION None	
89. SIGNATURE OF CHIEF OF BUREAU None		90. SIGNATURE OF DEPUTY CHIEF None	
91. SIGNATURE OF ASSISTANT CHIEF None		92. SIGNATURE OF CLERK None	
93. SIGNATURE OF RECEPTIONIST None		94. SIGNATURE OF TELEPHONE OPERATOR None	
95. SIGNATURE OF MAIL ROOM None		96. SIGNATURE OF RECORDS SECTION None	
97. SIGNATURE OF CHIEF OF BUREAU None		98. SIGNATURE OF DEPUTY CHIEF None	
99. SIGNATURE OF ASSISTANT CHIEF None		100. SIGNATURE OF CLERK None	

BUREAU V. 2

DEC 6 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12537

CERTIFICATE OF DEATH

12525

Reg. Dist. No. 185

1. PLACE OF DEATH o. COUNTY <i>Harford Maryland</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Chase Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Chase Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>none</i>		d. STREET ADDRESS <i>807 Otsego</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Ida Ferrandicco</i>		4. DATE OF DEATH Month Day Year <i>12/14/56</i> 19 <i>56</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/29/1883</i>
9. AGE (In years, last birthday) <i>73</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wif</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>Italy</i> ✓	
13. FATHER'S NAME <i>Louis Ferritti</i>		14. MOTHER'S MAIDEN NAME <i>Theresa Tosti</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Frank Ferrandicco</i>		Address <i>807 Otsego St. Harford Chase Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma left Mammary</i> DUE TO <i>Island</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Benign Carcinomatosis</i> DUE TO <i>Cachexia</i> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb</i> , 19 <i>56</i> , to <i>12/14</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>12/14</i> , 19 <i>56</i> , and that death occurred at <i>9:30 P.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles J. Foley</i> M.D.		ADDRESS (Street, city or town, state) <i>400 O'Malley Ave Md 1346</i>	
PHYSICIAN'S NAME (Type) <i>Charles J. Foley</i>		DATE SIGNED <i>12/16/56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/18/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Erin</i>		22d. LOCATION (City, town, or county) (State) <i>Harford Chase Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Thurston P. Harford Chase Md.</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>U. L. Lewis M.D.</i>		24b. REGISTRAR'S SIGNATURE	
DATE <i>12-18-56</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 21 1956

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12526

Reg. Dist. No.

181

12551

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	c. LENGTH OF STAY IN 1b <u>1 day</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOT APG Station Hospital</u>		d. STREET ADDRESS <u>Aberdeen Rural #1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Floyd F. Fleshman</u>		4. DATE OF DEATH Month Day Year <u>December 18 1956</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/9/1901</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operating Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>APG Goutus</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>James Lewis Fleshman</u>		14. MOTHER'S M maiden NAME <u>Laura Ann Keyser</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-054988</u>		
17. INFORMANT <u>MRS Floyd F. Fleshman</u>		Address <u>Aberdeen #1-rd.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>-</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> <u>Gerald C Palmer</u>				
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Harford County</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/21/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spesutta Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Perryman</u>		(State) <u>MD</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Garrison</u>		ADDRESS <u>Aberdeen, MD</u>		
24a. REC'D BY REGISTRAR <u>Dec. 19-56</u>		24b. REGISTRAR'S SIGNATURE <u>Nellie R Perry</u>		

DEC 21 1956

12538

CERTIFICATE OF DEATH

Reg. Dist. No.

180

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>415 S. Stokes St.</u>		d. STREET ADDRESS <u>415 S. Stokes St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Lemuel</u> Middle <u>Hiddings</u> Last <u></u>		4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 27, 1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Disable</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. George Pimori - Lancaster, Pa.</u>		Address <u>539 mercy ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u>Cerebral Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/18</u> 19 <u>50</u> , to <u>12/28</u> 19 <u>56</u> , that I last saw the deceased alive on <u>12/28</u> 19 <u>56</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George J. Stansbury</u>		ADDRESS (Street, city or town, state) <u>564 Revolution St., Harre de Grace, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		DATE SIGNED <u>12/29/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 3, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. James 9 M.E. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Harre de Grace Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stella J. Bullock</u>		ADDRESS <u>536 Larrin St.</u>	
24a. REC'D BY REGISTRAR <u>Jan. 2-57</u>		24b. REGISTRAR'S SIGNATURE <u>A. J. Smith M. d.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12528

CERTIFICATE OF DEATH

12558

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bel Air RD</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bel Air</u>		32	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Convalescent Home</u>				STREET ADDRESS (If rural give location) 1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>KATHERINE</u> (Middle) <u>REED</u> (Last) <u>GRAY</u>				(Month) <u>DEC</u> (Day) <u>22</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb 5, 1879</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Dent. Store Repair</u>	11. BIRTHPLACE (State or foreign country) <u>Warettsville Md USA</u>	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>Joshua Gray</u>				14. MOTHER'S MAIDEN NAME <u>Martha Jane Kurtz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>217-12-6627</u>		17. INFORMANT & ADDRESS <u>Mrs Ralph McGarri Bel Air Md</u>			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>CARDIO-RESPIRATORY FAILURE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>	
ANTECEDENT CAUSE(S) DUE TO <u>HYPOSTATIC PNEUMONIA.</u>						<u>4 DAYS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>ADVANCED ARTERIO SCLEROSIS</u>						<u>3 YEARS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1953</u> , to <u>17 DEC</u> , <u>1956</u> , that I last saw the deceased alive on <u>17 DEC</u> , <u>1956</u> , and that death occurred at <u>12:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>H. P. Adie</u>		M.D. <u>401 Franklin St. Bel Air Md</u>		DATE SIGNED <u>22 DEC 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-24-56</u>		NAME OF CEMETERY OR CREMATORY <u>Goodwill</u>		LOCATION (City, town, or county) (State) <u>Ruthledge Harford Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Prunella Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Martha Jane Kurtz</u>		ADDRESS	
DATE <u>12-29-56</u>							

1
RECEIVED
JAN 3 1957

RECEIVED
JAN 3 1957
BUREAU V. 52

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. PLACE OF DEATH	
JAMES EARL RAY		M		35		W		JAN 4 1957		MEMPHIS, TENN.	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
Attorney		Suicide		Suicide		[Signature]		[Signature]		[Signatures]	
13. MEDICAL EXAMINATION		14. BURIAL		15. REMARKS		16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF PHYSICIAN	
[Signature]		[Signature]		[Text]		[Signature]		[Signatures]		[Signature]	

RECEIVED

JAN 3 1957

BUREAU V. 52

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **12529**

12539

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u> c. LENGTH OF STAY IN 1b <u>10 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> d. STREET ADDRESS <u>RFD 2, Box 174</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First <u>Maston</u> Middle <u>Hall</u> Last <u>Hall</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>24</u> Year <u>1956</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 28, 1892</u>		9. AGE (In years last birthday) <u>64</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House Const.</u>				11. BIRTHPLACE (State or foreign country) <u>Smith Co. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>											
13. FATHER'S NAME <u>Ira Hall</u>						14. MOTHER'S MAIDEN NAME <u>Caroline Bonham</u>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>217-16-4788</u>		17. INFORMANT <u>Ralph Hall</u> Address <u>Robin Hood Rd. Bel Air, Md.</u>															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>993x Subdural Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Multiple contusions of Face & Neck</u> </td> <td rowspan="2" style="vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH </td> </tr> <tr> <td colspan="2"> (b) DUE TO (c) </td> </tr> </table>												PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>993x Subdural Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Multiple contusions of Face & Neck</u>		INTERVAL BETWEEN ONSET AND DEATH	(b) DUE TO (c)						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>993x Subdural Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Multiple contusions of Face & Neck</u>		INTERVAL BETWEEN ONSET AND DEATH																			
(b) DUE TO (c)																					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																					
ACTUAL SIGNATURE <u>William V. Ford</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <u>12-25-56</u>												
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>												
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12/28/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham</u>				22d. LOCATION (City, town, or county) (State) <u>Colorado</u> <u>Md.</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. B. McHallen</u>						ADDRESS <u>Rising Sun, Md.</u>		24a. REC'D. BY REGISTRAR <u>12/31/56</u>		24b. REGISTRAR'S SIGNATURE <u>Abraham A</u>											

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 31 1956
BUREAU OF
MEDICAL EXAMINER

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12530

12540 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haver de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DoA Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>411 Edmund</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clinton Hariston</u>		4. DATE OF DEATH <u>December 2</u> 19 <u>56</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9 August 1903</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>235-26-2400</u>	
17. INFORMANT <u>Mary E. Lawson</u>		Address <u>411 Edmund St. Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C. Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C. Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <u>Hartford Co</u>		DATE SIGNED <u>12-3-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/6/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Rd. Aberdeen, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Harvey</u>		ADDRESS <u>Aberdeen MD</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is mostly blank with some faint markings.

RECEIVED
DEC 10 1956
BUREAU V. S.

12541
CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Have de Grace</u>		c. LENGTH OF STAY IN 1b <u>18 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>			d. STREET ADDRESS <u>183 Old Post Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Ford</u> Last <u>Henderson</u>			4. DATE OF DEATH Month <u>December</u> Day <u>21</u> Year <u>1956</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 21-1921</u>	9. AGE (In years last birthday) <u>35</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>1</u> Hours <u>56</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superintendent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Concrete Business</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Herman Henderson</u>			14. MOTHER'S MAIDEN NAME <u>Olivia Reedy</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>War II</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Stella Barnes Henderson</u> Address <u>183 Old Post Rd, Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anteroseptal Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> (c) <u>Coronary atherosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>2 months</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>Dec. 20th, 1956</u> , to <u>Dec. 21st, 1956</u> , that I last saw the deceased alive on <u>Dec. 21</u> , 19 <u>56</u> , and that death occurred at <u>8:10 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____					
ACTUAL SIGNATURE <u>Edward C. Foo</u> M.D.		211 North Union Ave.		12/21/56	
PHYSICIAN'S NAME (Type) <u>Edward C. Foo, M.D.</u>		<u>Have de Grace, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/24/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	22d. LOCATION (City, town, or county) <u>Bel Air, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barriery</u>		ADDRESS <u>Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Dec 26-56</u>	24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis m.d.</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12559

CERTIFICATE OF DEATH

Reg. Dist. No.

12532

1. PLACE OF DEATH a. COUNTY Harford Co., MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DARLINGTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Streett			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last Patrick Hickey				4. DATE OF DEATH Month Day Year 12 3rd 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1869		9. AGE (In years last birthday) yrs. 87	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Veterinarian			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Patrick Hickey				14. MOTHER'S MAIDEN NAME Ellen ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Catherine Hickey, 4315 Underwood Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Old Age 794x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Median Sharp	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/27 , 19 56 , to 12/3 , 19 56 ; that I last saw the deceased alive on 11/27 , 19 56 , and that death occurred at 8 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Dudley Phillips				ADDRESS (Street, city or town, state) Darlington Md			
PHYSICIAN'S NAME (Type) Dudley Phillips				DATE SIGNED 12/4/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-5-56		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook Ince, 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE 12/4/56		24b. REGISTRAR'S SIGNATURE Priscilla Forward	

CERTIFICATE OF DEATH

Date of Death Dec 5 1956		Place of Death Baltimore, Md.	
Name of Deceased [Illegible]		Sex Male	
Date of Birth [Illegible]		Age [Illegible]	
Usual Residence [Illegible]		Cause of Death [Illegible]	
Immediate Cause [Illegible]		Contributing Cause [Illegible]	
Manner of Death [Illegible]		Physician's Signature [Illegible]	
Date of Report Dec 5 1956		Registrar's Signature [Illegible]	

BUREAU V. S.

DEC 5 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 181

12560

1. PLACE OF DEATH o. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford c. LENGTH OF STAY IN 1b 5 min d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Aberdeen Maryland 2151-1 USAH, Aberdeen Proving Ground Md				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) o. STATE Harford Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen, Maryland d. STREET ADDRESS 2151-1 USAH e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Infant		First Huelskamp		Last Huelskamp		4. DATE OF DEATH Month 30 Dec Day 30 Year 1956	
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 30 Dec 1956		9. AGE (In years last birthday) yrs. 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) 2151-1 USAH, Aberdeen, Md		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Paul B Huelskamp				14. MOTHER'S MAIDEN NAME Marjory Marie Moeder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N/A		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Paul B Huelskamp Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 30 Dec , 19 56 , to 30 Dec , 19 56 , that I last saw the deceased alive on 30 Dec , 19 56 , and that death occurred at 8:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 30 Dec 56 STATE SIGNED ACTUAL SIGNATURE V. A. Coseriu M.D. 2151-1 USAH, Aberdeen Proving Ground Md PHYSICIAN'S NAME (Type) V.A. Coseriu							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Jan 3-1957		22c. NAME OF CEMETERY OR CREMATORY Post Cemetery		22d. LOCATION (City, town, or county) (State) Aberdeen Proving Ground Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John E. Sarny ADDRESS Aberdeen Md				24a. REC'D BY REGISTRAR Jan 3-57		24b. REGISTRAR'S SIGNATURE Nellie E. Perry	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12534

Reg. Dist. No.

12542

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harpe de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial Hspital</u>		d. STREET ADDRESS <u>R D #1</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Leslie</u> Last <u>Hughes</u>		4. DATE OF DEATH Month <u>December</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6th 1886</u>
9. AGE (In years lost birthday) yrs. <u>70</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>American Can Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oliver Hughes</u>		14. MOTHER'S MAIDEN NAME <u>Estelle Morgan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Wm R. Leslie Hughes Aberdeen Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary artery thrombosis</u> DUE TO (c) <u>Coronary arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 days</u> <u>5-10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Exogenous obesity</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 2, 1955</u> to <u>Dec 14, 1956</u> , that I last saw the deceased alive on <u>Dec 14, 1956</u> , and that death occurred at <u>10:35 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. J. Plunkett, Jr.</u>		ADDRESS (Street, city or town, state) <u>617 W. BELAIR AVE</u>	
PHYSICIAN'S NAME (Type) <u>B. J. Plunkett Jr.</u>		DATE SIGNED <u>12-14-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/17/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Ann's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Perryman Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Harrington Aberdeen Md</u>		24a. REC'D BY REGISTRAR <u>A. L. Lewis</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>12-19-56</u>	

CERTIFICATE OF DEATH

1

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BUREAU V. S.

DEC 31 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

12535

182

Reg. Dist. No. 182

12561

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL or give nearest town) <u>Bel-Air Rural</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel-Air Rural</u>		TOWN <u>Bel-Air Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>County Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>George Johnson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 9, 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1876 about 80</u>	9. AGE last birthday <u>80</u> yrs.	10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer on farm</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Harford Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wall Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Rhene Giles</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-32-7398</u>		17. INFORMANT & ADDRESS <u>B. Johnson & Johnson Street, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Carcinoma of Prostate -- Generalized metastases</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>X</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 10, 1958</u> to <u>Dec. 9, 1956</u> , that I last saw the deceased alive on <u>Dec. 2, 1956</u> , and that death occurred at <u>11:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city, town, state) <u>Forest Hill, Md</u>		DATE SIGNED <u>12-10-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Dec. 12, 1956</u>		NAME OF CEMETERY OR CRMATORY <u>Clark's Chapel Cn</u>		LOCATION (City, town or county) <u>Harford Co Md</u>	
24. REC'D BY REGISTRAR <u>Dec. 12, 1956</u>		REGISTRAR'S SIGNATURE <u>Penilla L. L. L.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		ADDRESS <u>Baltimore, Md</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. S.

DEC 17 1956

RECEIVED

12543

CERTIFICATE OF DEATH

Reg. Dist. No.

186-

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haure de Grace</u>		c. LENGTH OF STAY IN 1b <u>5 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haure de Grace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>700 Revolution St.</u>					
3. NAME OF DECEASED (Type or print) First <u>Kenneth</u> Middle <u>L</u> Last <u>Kintzel</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 8, 1890</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refrigeration Engineer Edgewood Canal</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Penna</u>		11. BIRTHPLACE (State or foreign country) <u>Penna</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Roger Kintzel</u>				14. MOTHER'S MAIDEN NAME <u>Alice Seitzinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Harold P. Kintzel Jr. 700 Revolution St. Haure de Grace, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Sclerosis Cardio Vascu-</u> <u>420.1</u> DUE TO <u>late Onian</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO (c) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 1949</u> , to <u>Dec 12 1956</u> that I last saw the deceased alive on <u>Dec 12, 1956</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles J. Foley</u> M.D.				ADDRESS (Street, city or town, state) <u>400 W. Main St. Haure de Grace, Md.</u>			
PHYSICIAN'S NAME (Type) <u>CHARLES J. FOLEY</u>				DATE SIGNED <u>12/13/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/15/56</u>		<u>Oddfellows</u>		<u>Tanagers Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pennington & Son, Haure de Grace, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 12-15-56</u>		24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12537

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Del. Va.</u> b. COUNTY <u>49X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stilwell</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>US Route 1</u>		d. STREET ADDRESS <u>US Route 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Jack</u> Middle <u>—</u> Last <u>Lunston</u>		4. DATE OF DEATH Month <u>December</u> Day <u>2</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 11 - 1923</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Army</u>	9. AGE (In years last birthday) <u>33</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>No record.</u>		14. MOTHER'S MAIDEN NAME <u>No record.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes. Current Enlistment</u>		16. SOCIAL SECURITY NO. <u>No record.</u>	
17. INFORMANT <u>Quartermaster Dept. A.P.G. Md.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull, compound, comminuted</u> DUE TO <u>819X</u> Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (c) <u>—</u> DUE TO <u>—</u> stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>None</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto-object type</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-2-56</u> Hour <u>0250</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <u>US Route 1</u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bel Air Harford Md.</u>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C. Palmer</u>		DATE SIGNED <u>12-2-56</u>	
EXAMINER'S NAME (Type) <u>Gerald C. Palmer-MD</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <u>Harford Co.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>12/3/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>—</u>	22d. LOCATION (City, town, or county) (State) <u>Statesboro Georgia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Garring Aberdeen Md.</u>		24a. REC'D BY REGISTRAR <u>Dec 3-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Nellie R. Pruy</u>	

1
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 5 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12563 CERTIFICATE OF DEATH

Reg. Dist. No. 125382

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Harford</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Harford</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Street Rural</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Street Rural</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <i>Joseph E. Motson</i>		4. DATE OF DEATH (Month) <i>Dec</i> , (Day) <i>3</i> , (Year) <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Feb 25 1875</i>
9. AGE last birthday <i>81</i> yrs.		10. IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Harford Co, Md</i>	
11. BIRTHPLACE (State or foreign country) <i>Harford Co, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Thomas Motson</i>		14. MOTHER'S MAIDEN NAME <i>Blanche James</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>146-106297</i>	
17. INFORMANT & ADDRESS <i>Mrs. Alice Rokey Street, md</i>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		19. MEDICAL CERTIFICATION	
19a. IMMEDIATE CAUSE (A) <i>4201 Coronary occlusion</i>		19b. ANTECEDENT CAUSE(S) DUE TO <i>Arteriosclerotic cardiovascular disease 8 mo.</i>	
19c. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <i></i>		19d. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i></i>	
19e. DATE OF OPERATION		19f. MAJOR FINDINGS OF OPERATION	
20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
22. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>M.</i>		23. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>	
24. WHERE DID INJURY OCCUR? (City or town) (County) (State)		25. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>July 21</i> , 19 <i>56</i> , to <i>Dec 3</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Nov 9</i> , 19 <i>56</i> , and that death occurred at <i>3:41</i> A.M. from the causes and on the date stated above.			
SIGNATURE <i>Charles Craft</i>		DATE SIGNED <i>Dec 3, 1956</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24. DATE THEREOF <i>Dec 6, 1956</i>	
25. NAME OF CEMETERY OR CREMATORY <i>Harlington-Cem</i>		26. LOCATION (City, town, or county) <i>Harford Co, md</i>	
27. REC'D BY REGISTRAR <i>C. H. Kirk</i>		28. REGISTRAR'S SIGNATURE <i>H. S. Bailey</i>	
29. DATE <i>Dec 5, 1956</i>		30. FUNERAL DIRECTOR'S SIGNATURE <i>H. S. Bailey</i>	

CERTIFICATE OF DEATH

1956

1. LAST NAME OF DECEASED: *WILLIAMS*
2. FIRST NAME OF DECEASED: *JOHN*
3. MIDDLE NAME OF DECEASED: *WILLIAM*
4. SEX: *MALE*
5. AGE: *65*
6. DATE OF BIRTH: *1911*
7. PLACE OF BIRTH: *MD*
8. OCCUPATION: *DRIVER*
9. CAUSE OF DEATH: *HEART DISEASE*
10. PLACE OF DEATH: *HOME*
11. DATE OF DEATH: *DEC 11 1956*
12. SIGNATURE OF PHYSICIAN: *[Signature]*
13. SIGNATURE OF REGISTRAR: *[Signature]*

CHICAGO, ILL

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS LOANED TO YOU FOR YOUR INFORMATION. IT IS NOT TO BE REPRODUCED OR TRANSMITTED IN ANY FORM OR BY ANY MEANS, ELECTRONIC OR MECHANICAL, INCLUDING PHOTOCOPYING, RECORDING, OR BY ANY INFORMATION STORAGE AND RETRIEVAL SYSTEM. ANY VIOLATION OF THIS NOTICE IS A VIOLATION OF THE FEDERAL COPYRIGHT ACT OF 1976 AND IS SUBJECT TO CIVIL AND CRIMINAL PENALTIES.

BUREAU V. S.

DEC 11 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12539

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>None</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rock Spring Ave</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill (Rural)</u>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert E Pennington</u>		4. DATE OF DEATH <u>December 6 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1922</u>
9. AGE (In years last birthday) <u>34</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager - Bus Service Station</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Konmarack Va</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Harvey L Pennington</u>		14. MOTHER'S MAIDEN NAME <u>Sue Pennington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>223-20-0479</u>	
17. INFORMANT <u>John Pennington</u>		Address <u>Forest Hill Md (Rural)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull, compound</u> DUE TO <u>816x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture L. patella, comminuted</u>		INTERVAL BETWEEN ONSET AND DEATH <u>-</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto-autotype</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-6 1956</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rock Spring Ave</u>		20f. (City or town) <u>Bel Air</u> (County) <u>Hartford</u> (State) <u>md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>L. C. Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Hartford County</u>		DATE <u>12-6-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 8-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u>		ADDRESS <u>Bel Air Md</u>	
24a. REC'D BY REGISTRAR <u>12-7-56</u>		24b. REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Faint text]
2. SEX: [Faint text]
3. AGE: [Faint text]
4. RACE: [Faint text]
5. OCCUPATION: [Faint text]
6. PLACE OF BIRTH: [Faint text]
7. DATE OF BIRTH: [Faint text]
8. DATE OF DEATH: [Faint text]
9. TIME OF DEATH: [Faint text]
10. PLACE OF DEATH: [Faint text]
11. CAUSE OF DEATH: [Faint text]
12. MANNER OF DEATH: [Faint text]
13. SIGNATURE OF EXAMINER: [Faint text]
14. OFFICE OF EXAMINER: [Faint text]
15. COUNTY: [Faint text]

RECEIVED
DEC 10 1956
BUREAU V. S.

12564

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN lb <u>60 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RD 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Wiley</u> Middle <u>M</u> Last <u>Plummer</u>		4. DATE OF DEATH Month <u>December</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 3 - 1897</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Quarry</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert M. Plummer</u>		14. MOTHER'S MAIDEN NAME <u>Flora Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-03-9319</u>	
17. INFORMANT <u>Wm. R. Wasilek</u>		Address <u>Cherden Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Third degree burns chest/body</u> 916.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>His parked car caught fire</u>	
20c. TIME OF INJURY Hour <u>11:40</u> p.m. Month, Day, Year <u>12-25-56</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Gates Quarry</u>	20f. (City or town) <u>Bel Air</u> (County) <u>Hartford</u> (State) <u>md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> EXAMINER'S NAME (Type) <u>Bel Air, Md.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Hartford County</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/28/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Mem. Gardens</u>	22d. LOCATION (City, town, or county) <u>Bel Air Maryland</u> (State) <u>md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Carrying</u> ADDRESS <u>Cherden Rd.</u>		24a. REC'D BY REGISTRAR <u>Dec 26 - 56</u>	24b. REGISTRAR'S SIGNATURE <u>Willie R. Perry</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 13
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		45		M		W		12-15-56		BALTIMORE, MD.	
RESIDENT OF BALTIMORE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL		DATE OF BURIAL	
YES		FIREMAN		HEART DISEASE		NATURAL		BALTIMORE, MD.		12-15-56	
DATE OF EXAMINATION		BY		SIGNATURE OF EXAMINER		TITLE		DATE OF EXAMINATION		BY	
12-15-56		J. J. JONES		J. J. JONES		M.D.		12-15-56		J. J. JONES	
DATE OF EXAMINATION		BY		SIGNATURE OF EXAMINER		TITLE		DATE OF EXAMINATION		BY	
12-15-56		J. J. JONES		J. J. JONES		M.D.		12-15-56		J. J. JONES	

RECEIVED
 DEC 15 1956
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1254185

12545

CERTIFICATE OF DEATH

Reg. Dist. No.

96

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laws de Grace</u>		c. LENGTH OF STAY IN 1b <u>34 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>High St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Maef</u> Last <u>Price</u>				4. DATE OF DEATH Month <u>December</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-14-1869</u>		9. AGE (In years last birthday) <u>87</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Nesbitt</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Name <u>Mrs. James L. Lentman</u> Address <u>Port Deposit, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerosis</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Thrombosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1956</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 10, 1956</u> , to <u>Dec 30, 1956</u> , that I last saw the deceased alive on <u>Dec 30, 1956</u> , and that death occurred at <u>11:45 A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clarence L. Benson</u> M.D.				ADDRESS (Street, city or town, state) <u>Port Deposit Md.</u> DATE SIGNED <u>12/31/56</u>			
PHYSICIAN'S NAME (Type) <u>Clarence L. Benson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-2-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Port Deposit Md. Rural</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Laura Patterson & Son, Perryville, Md</u>				24a. REC'D BY REGISTRAR DATE <u>12-31-56</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. L. L. Lewis</u>	

RECEIVED

12546

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b <u>6 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>1111</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Edward Singleton</u>				4. DATE OF DEATH <u>December 17</u> 19 <u>56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-98</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>Chesapeake Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>STEPHEN SINGLETON</u>				14. MOTHER'S MAIDEN NAME <u>PRISCILLA SAMPSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>BERTHA C. GRISSON, HAVRE DE GRACE, P.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>541.1</u> DUE TO <u>Spontaneous</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Spontaneous</u> DUE TO <u>Perforated duodenum</u> (c) <u>Perforated duodenum</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-7-56</u> to <u>12-17-56</u> , that I last saw the deceased alive on <u>12-17-56</u> , and that death occurred at <u>6:25 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm. K. Brindle</u> M.D.				ADDRESS (Street, city or town, state) <u>HAVRE DE GRACE, MD</u> DATE SIGNED <u>12-17-56</u>			
PHYSICIAN'S NAME (Type) <u>Wm. K. Brindle</u>				ADDRESS <u>HAVRE DE GRACE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-19-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>ABERDEEN/HARFORD MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>				ADDRESS <u>Havre de Grace, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>12-19-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis, M.D.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

BUREAU V. 3

DEC 21 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12543

Reg. Dist. No. 182

12547

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEL AIR		c. LENGTH OF STAY IN 1b 21 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEL AIR		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 29 W. COURTLAND AVE				d. STREET ADDRESS AEGIS APTS 29 W COURTLAND			
3. NAME OF DECEASED (Type or print) First NORMAN Middle A Last SPAHR				4. DATE OF DEATH Month DEC Day 23 Year 19 56			
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL-1-1886		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MAN		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MILTON O. SPAHR				14. MOTHER'S MAIDEN NAME ALICE REMSBERG			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 214-03-5984		17. INFORMANT Address MABLE PATTERSON SPAHR (SAME)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA BRONCHIAL 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL VASCULAR ACCIDENT (2ND) DUE TO ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE (c) OVER 10 YRS </p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH 24 HRS 4 DAYS OVER 10 YRS </p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture cervical 7 compression spinal cord - partial paraplegia.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Had stroke while driving automobile - ran off road struck pole and ditch					
20c. TIME OF INJURY Hour 8:00 Month JULY Day 13 Year 19 56	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway between CHESTERTOWN & MIDDLETOWN, DE		20f. (City or town) Bel Air		20g. (County) Harford	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Philip W. Heuman				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) PHILIP W. HEUMAN				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 26/56		22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		22d. LOCATION (City, town, or county) (State) Bel Air Harford Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Ford				ADDRESS Bel Air Md		24a. REC'D BY REGISTRAR DATE 12-25-56	
						24b. REGISTRAR'S SIGNATURE Burilla Lowood	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

DEC 27 1956

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12544

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover Trace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>RD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ellis</u> Middle <u>Priscilla</u> Last <u>Streett</u>		4. DATE OF DEATH Month <u>December</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-14-71</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Noah Bull</u>		14. MOTHER'S MAIDEN NAME <u>Dryden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Math E Streett Bel Air MD</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture L. Femur</u> DUE TO <u>903.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic CV disease</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall on floor</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> <u>2-14-56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u> </u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Bel Air</u> (County) <u>Harford</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Bel Air MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12-14-56</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 16/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Deer Creek Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Harford MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph H. Bel Air MD</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

IN COUNTY

AT PLACE

CITY AND STATE

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF EXAMINATION

PLACE OF EXAMINATION

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF EXAMINATION

PLACE OF EXAMINATION

EDUCATION

OCCUPATION

RELIGION

BUREAU V. 1

DEC 17 1956

RECEIVED

12565

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace Rural #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural #1 Robin Hood Rd.</u>		d. STREET ADDRESS <u>Robin Hood Road.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arny</u> Middle <u>B.</u> Last <u>Swinger</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>25th</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 29 1884</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>72</u> Days <u>72</u> Hours <u>72</u> Min. <u>72</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Vermont</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Manning</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Cote</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>008-17-6358</u>	
17. INFORMANT <u>June R. Swinger</u>		Address <u>#1. rd Harford Grace</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of vomitus</u> DUE TO <u>157X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of head of pancreas</u> DUE TO (c) <u>14 MOS.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 MINUTES</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 6</u> , 19 <u>55</u> , to <u>Dec 25</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Sept 28</u> , 19 <u>56</u> , and that death occurred at <u>6:30</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. J. Plunkett, Jr.</u>		ADDRESS (Street, city or town, state) <u>617 W. Belair Ave</u> DATE SIGNED <u>12-26-56</u>	
PHYSICIAN'S NAME (Type) <u>Abertdeen, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>12/26/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fair View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Burlington Vermont.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Garring</u>		ADDRESS <u>Abertdeen Md</u>	
24a. REC'D BY REGISTRAR <u>Dec 26-56</u>		24b. REGISTRAR'S SIGNATURE <u>Nellie R. Perry</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 28 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12546

12566

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belcamp</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belcamp</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>#3 Beta Drive</u>		d. STREET ADDRESS <u>#3 Beta Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Jeann</u> Middle <u>Helke</u> Last <u>Urban</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>26th</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 13-1921</u>
9. AGE (In years last birthday) <u>35</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry P. Bratter</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Loosbrook</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>510-12-8784</u>	
17. INFORMANT <u>Frank T. Urban</u>		Address <u>#3 Beta Drive</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>170X</u> DUE TO <u>Carcinoma of the breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 1</u> , 19 <u>56</u> , to <u>Dec. 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 26</u> , 19 <u>56</u> , and that death occurred at <u>11:45aM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Warfield M. Firor</u>		ADDRESS (Street, city or town, state) <u>1101 N. Calvert St., Baltimore 2.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Warfield M. Firor</u>		DATE SIGNED <u>12/27/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/29/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>abersdeen maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barriag</u>		24a. REC'D BY REGISTRAR <u>Dec 29-56</u>	
ADDRESS <u>abersdeen md</u>		24b. REGISTRAR'S SIGNATURE <u>Nellie R. Perry</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>		<p>3. AGE [Faint text]</p>	
<p>4. DATE OF DEATH [Faint text]</p>		<p>5. TIME OF DEATH [Faint text]</p>		<p>6. PLACE OF DEATH [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>		<p>9. SIGNATURE OF DECEASED [Faint text]</p>	
<p>10. SIGNATURE OF WITNESS [Faint text]</p>		<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF CORONER [Faint text]</p>	
<p>13. SIGNATURE OF JURY [Faint text]</p>		<p>14. SIGNATURE OF JUDGE [Faint text]</p>		<p>15. SIGNATURE OF CLERK [Faint text]</p>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12547

12549

1. PLACE OF DEATH a. COUNTY <u>Darford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Darford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sagnette Green</u>		c. LENGTH OF STAY IN 1b <u>Charlottesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Darford Memorial Hospital</u>		d. STREET ADDRESS <u>Charlottesville</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Madell</u> Last <u>Van Swearingen</u>		4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-7-1918</u>
9. AGE (In years last birthday) <u>38</u> yrs.		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>3</u> Hours <u>3</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Radio Dispatcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Taxi-Cab</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Reginald Headland</u>		14. MOTHER'S MAIDEN NAME <u>Muriel Tracy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-01-0586</u>	
17. INFORMANT <u>D.D. Van Swearingen</u>		Address <u>Darlington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Vascular disease</u> DUE TO (c) <u>> 18 mos</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-22-1955</u> to <u>9-26-1955</u> , that I last saw the deceased alive on <u>12-3-56</u> , 19 <u>56</u> , and that death occurred at <u>4:22 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B.J. Plunkett, Jr.</u>		ADDRESS (Street, city or town, state) <u>617 W. BELAIR AVE</u>	
PHYSICIAN'S NAME (Type) <u>B.J. Plunkett Jr. M.D.</u>		DATE SIGNED <u>12-4-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/7/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Sarring</u>		ADDRESS <u>Aberdeen Md.</u>	
24a. REC'D BY REGISTRAR <u>12-7-56</u>		24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>	

CERTIFICATE OF DEATH

1. Name of Deceased: John Doe
 2. Sex: Male
 3. Age: 45
 4. Date of Birth: 1910-03-15
 5. Place of Birth: John Doe, Maryland
 6. Date of Death: 1956-12-10
 7. Place of Death: John Doe, Maryland
 8. Cause of Death: Heart Disease
 9. Manner of Death: Natural
 10. Signature of Physician: John Doe, M.D.
 11. Signature of Registrar: John Doe
 12. Date of Registration: 1956-12-10

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